



### Admission Information

Use this form to collect all required information about a child enrolling in day care.

**Directions:** The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

#### General Information

Operation's Name:		Director's Name:	
Child's Full Name:		Child's Date of Birth:	Child Lives With? <input type="radio"/> Both parents <input type="radio"/> Mom <input type="radio"/> Dad <input type="radio"/> Guardian
Child's Home Address:		Date of Admission:	Date of Withdrawal:
Name of Parent or Guardian Completing Form:		Address of Parent or Guardian (if different from the child's):	
List phone numbers below where parents or guardian may be reached while child is in care.			
Parent 1 Phone No.:	Parent 2 Phone No.:	Guardian's Phone No.:	Custody Documents on File? <input type="radio"/> Yes <input type="radio"/> No
<b>In case of an emergency, call:</b>			
Name of Emergency Contact:		Relationship:	Area Code and Phone No.:
Address:			
I authorize the child care operation to <b>release</b> my child to leave the child care operation <b>ONLY</b> with the following persons. Please list name and phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent or guardian after verification of ID.			
Name:		Area Code and Phone No.:	
Name:		Area Code and Phone No.:	
Name:		Area Code and Phone No.:	

#### Consent Information

<b>1. Transportation:</b>
I give consent for my child to be transported and supervised by the operation's employees (Check all that apply). <input type="checkbox"/> for emergency care <input type="checkbox"/> on field trips <input type="checkbox"/> to and from home <input type="checkbox"/> to and from school
<b>2. Field Trips:</b>
<input type="radio"/> I give consent for my child to participate in field trips. <input type="radio"/> I do not give consent for my child to participate in field trips.
Comments:
<div style="border: 1px solid black; height: 100px;"></div>

**3. Water Activities:**

I give consent for my child to participate in the following water activities (Check all that apply).

- water table play    sprinkler play    splashing or wading pools    swimming pools    aquatic playgrounds

Is your child able to swim without assistance?

- Yes    No

Does your child have any physical, health, behavioral or other condition that would put them at risk while swimming?

- Yes    No

Do you want your child to wear a life jacket while in or near a swimming pool?

- Yes    No

**4. Receipt of Written Operational Policies:**

I acknowledge receipt of the facility's operational policies, including those for (Check all that apply).

- |  |  |
|--|--|
| <input type="checkbox"/> Discipline and guidance   | <input type="checkbox"/> Procedures for release of children  |
| <input type="checkbox"/> Suspension and expulsion  | <input type="checkbox"/> Illness and exclusion criteria  |
| <input type="checkbox"/> Emergency plans   | <input type="checkbox"/> Procedures for dispensing medications   |
| <input type="checkbox"/> Procedures for conducting health checks   | <input type="checkbox"/> Immunization requirements for children  |
| <input type="checkbox"/> Safe sleep  | <input type="checkbox"/> Meals and food service practices  |
| <input type="checkbox"/> Procedures for parents to discuss concerns with the director  | <input type="checkbox"/> Procedures to visit the center without securing prior approval  |
| <input type="checkbox"/> Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions | <input type="checkbox"/> Procedures for supporting inclusive services  |
| <input type="checkbox"/> Procedures for parents to participate in operation activities                                       | <input type="checkbox"/> Procedures for parents to contact Child Care Regulation (CCR), DFPS, Child Abuse Hotline, and CCR website |

**5. Meals:**

I understand that the following meals will be served to my child while in care (Check all that apply):

- None    Breakfast    Morning snack    Lunch    Afternoon snack    Supper    Evening snack

**6. Days and Times in Care:**

My child is normally in care on the following days and times:

Day of the Week	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

**7. Receipt of Parent's Rights:**

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

\_\_\_\_\_  
Signature — Parent or Legal Guardian

\_\_\_\_\_  
Date Signed

**8. Child's Special Care Needs (check all that apply)**

- |  |   |
|--|---|
| <input type="checkbox"/> Environmental allergies                                 | <input type="checkbox"/> Limitations or restrictions on child's activities        |
| <input type="checkbox"/> Food intolerances                                       | <input type="checkbox"/> Reasonable accommodations or modifications               |
| <input type="checkbox"/> Existing illness  | <input type="checkbox"/> Adaptive equipment ( <i>include instructions below</i> ) |
| <input type="checkbox"/> Previous serious illness                                | <input type="checkbox"/> Symptoms or indications of complications                 |
| <input type="checkbox"/> Injuries and hospitalizations ( <i>past 12 months</i> ) | <input type="checkbox"/> Medications prescribed for continuous long-term use      |
| <input type="checkbox"/> Other: _____  |   |

Explain any needs selected above:

Does your child have diagnosed food allergies?  Yes  No Food Allergy Emergency Plan Submitted Date: \_\_\_\_\_

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit <https://www.ada.gov/resources/child-care-centers/>. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

\_\_\_\_\_  
Signature — Parent or Legal Guardian

\_\_\_\_\_  
Date Signed

**9. School Age Children**

My child attends the following school:

School Area Code and Phone No.:

My child has permission to (*check all that apply*):

- walk to or from school or home  ride a bus  be released to the care of his or her sibling under 18 years old

Authorized pick up or drop off locations other than the child's address:

Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

**Authorization For Emergency Medical Attention**

In the event I cannot be reached to arrange for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician	Address	Phone No.
Name of Emergency Care Facility	Address	Phone No.

I give consent for the facility to secure any and all necessary emergency medical care for my child.

\_\_\_\_\_  
Signature — Parent or Legal Guardian

\_\_\_\_\_  
Date Signed

**Requirements for Exclusion from Compliance**

- I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.
- I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

**Vision Exam Results**

Right Eye 20/      Left Eye 20/       Pass       Fail

Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

**Hearing Exam Results**

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				<input type="radio"/> Pass <input type="radio"/> Fail
Left				<input type="radio"/> Pass <input type="radio"/> Fail

Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

**Admission Requirement**

If your child does not attend pre-kindergarten or school away from the child care operation, one of the following must be presented when your child is admitted to the child care operation or within one week of admission. *(Select **only one** option.)*

- Health Care Professional's Statement: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.
- A signed and dated copy of a health care professional's statement is attached.
- Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.
- My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and submit it to the child care operation.

Name of Health Care Professional, if selected \_\_\_\_\_

Address of Health Care Professional, if selected \_\_\_\_\_

Signature — Health Care Professional \_\_\_\_\_

Date Signed \_\_\_\_\_

Signature — Parent or Legal Guardian \_\_\_\_\_

Date Signed \_\_\_\_\_

### Vaccine Information

The following vaccines require multiple doses over time. Please provide the date your child received each dose.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1–2 months (second dose)	
	6–18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15–18 months (fourth dose)	
	4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6–18 months (third dose)	
	4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose)	
	4–6 years (second dose)	
Varicella	12–15 months (first dose)	
	4–6 years (second dose)	
Hepatitis A	12–23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	

### Varicella (Chickenpox)

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about [date] and does not need varicella vaccine.

Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

### Additional Information Regarding Immunizations

For additional information regarding immunizations, visit the Texas Department of State Health Services website at [www.dshs.state.tx.us/immunize/public.shtm](http://www.dshs.state.tx.us/immunize/public.shtm).

### TB Test (If required)

Positive  Negative Date: \_\_\_\_\_

### Gang Free Zone

Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

### Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: <https://hhs.texas.gov/policies-practices-privacy#security>

### Signatures

Child's Parent or Legal Guardian \_\_\_\_\_

Date Signed \_\_\_\_\_

Center Designee \_\_\_\_\_

Date Signed \_\_\_\_\_

### Physician or Public Health Personnel Verification

Signature or stamp of a physician or public health personnel verifying immunization information above:

Signature \_\_\_\_\_

Date Signed \_\_\_\_\_



## Infant Sleep Exception/Health Care Professional Recommendation

When a health care professional determines that it is medically necessary for an infant to sleep in an alternative position (other than sleeping on the infant's back), sleep in a restrictive device (such as a bouncer seat or swing), or needs to be swaddled to sleep, use this form to ensure that a licensed child care center, licensed child care home, or registered child care home that cares for the infant meets the minimum standards required by Texas Human Resources Code §42.042(e)(8)(A) and (B). The standards for these operations require the operation to:

- follow the directions of an infant's health care professional to provide specialized medical assistance to the infant (746.3815 and 747.3615); and
- maintain, while active, this form and any other directions from the health care professional that the parent provides to the operation [See §746.603(a)(10) or §747.603(a)(9)]. Keep the exception form in the infant's classroom, so that a caregiver may refer to the health care professional's instructions.

**Directions:** This exception will not be effective until all sections and signatures are complete. Once completed, the exception is acceptable for use by the child care operation.

### Infant's Information

Infant's Name	Date of Birth	Infant's Age	Parent/Guardian's Name
Address			
Home Phone	Work Phone	Fax	Email

The infant's health care professional must complete the following section.

### Health Care Professional Information

Name of Infant's Health Care Professional	Name of Practice		
Address			Fax number
Work Phone	Home Phone	Email	

The Texas child care minimum standards (§§746.2426, 746.2427 and 746.2428 for child care centers or §§747.2326, 747.2327 and 747.2328 for licensed or registered child care homes) require child care operations to place all infants on their backs to sleep in a crib and to ensure that infants do not sleep in restrictive devices and are not laid down to sleep swaddled. But, based on the advice of the infant's health care professional, when medically necessary, the center may be authorized to use an alternative sleep position, restrictive device, or swaddle for the infant due to medical reasons.

The above named infant has the following medical condition that necessitates an alternative sleep position, allow for sleep in a restrictive device, or requires swaddling for sleeping:

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### Health Care Professional Information

Please describe the appropriate sleep position/restrictive device/swaddling technique to be used for the above named infant and include the effective dates for the exception:
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Effective Dates of Exception	From	To	
------------------------------	------	----	--

\_\_\_\_\_ Date

**Waiver of Liability**

- I affirm and acknowledge that the below named child care operation has provided me with the operation's safe sleep policy.
- I further authorize the child care operation and its caregivers to place my infant in an alternative sleep position, restrictive device, or swaddling at the recommendation of my infant's health care professional, as described above.
- I, as the parent or guardian of the above mentioned infant, release and hold harmless the below named child care operation, its officers, directors, caregivers, and employees from any and all liability whatsoever associated with harm to my infant due to Sudden Infant Death Syndrome (SIDS).

\_\_\_\_\_  
Date Signed

**An authorized official with the child care operation must complete the following section.**  
**Child Care Operation Information and Signature**

Name of Child Care Operation	Operation Number
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\_\_\_\_\_  
Date Signed

**Privacy Statement**

HHSC values your privacy. For more information, read our privacy policy online at: <https://hhs.texas.gov/policies-practices-privacy#security>.



## Operational Policy on Infant Safe Sleep

This form provides the required information per minimum standards §746.501(9) and §747.501(6) for the safe sleep policy.

**Directions:** Parents will review this policy upon enrolling their infant at \_\_\_\_\_ and a copy of the policy is provided in the parent handbook. Parents can review information on safe sleep and reducing the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death (SIDS/SUIDS) at: <http://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx>

### Safe Sleep Policy

All staff, substitute staff, and volunteers at \_\_\_\_\_ will follow these safe sleep recommendations of the American Academy of Pediatrics (AAP) and the Consumer Product Safety Commission (CPSC) for infants to reduce the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death Syndrome (SIDS/SUIDS):

- Always put infants to sleep on their backs unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional [§746.2427 and §747.2327].
- Place infants on a firm mattress, with a tight fitting sheet, in a crib that meets the CPSC federal requirements for full-size cribs and for non-full size cribs [§746.2409 and §747.2309].
- For infants who are younger than 12 months of age, cribs should be bare except for a tight fitting sheet and a mattress cover or protector. Items that should not be placed in a crib include: soft or loose bedding, such as blankets, quilts, or comforters; pillows; stuffed toys/ animals; soft objects; bumper pads; liners; or sleep positioning devices [§746.2415(b) and §747.2315(b)]. Also, infants must not have their heads, faces, or cribs covered at any time by items such as blankets, linens, or clothing [§746.2429 and §747.2329].
- Do not use sleep positioning devices, such as wedges or infant positioners. The AAP has found no evidence that these devices are safe. Their use may increase the risk of suffocation [§746.2415(b) and §747.2315(b)].
- Ensure that sleeping areas are ventilated and at a temperature that is comfortable for a lightly clothed adult [§746.3407(10) and §747.3203(10)].
- If an infant needs extra warmth, use sleep clothing \_\_\_\_\_ (insert type of sleep clothing that will be used, such as sleepers or footed pajamas) as an alternative to blankets [§746.2415(b) and §747.2315(b)].
- Place only one infant in a crib to sleep [§746.2405 and §747.2305].
- Infants may use a pacifier during sleep. But the pacifier must not be attached to a stuffed animal [§746.2415(b) and §747.2315(b)] or the infant's clothing by a string, cord, or other attaching mechanism that might be a suffocation or strangulation risk [§746.2401(6) and §747.2315(b)].
- If the infant falls asleep in a restrictive device other than a crib (such as a bouncy chair or swing, or arrives to care asleep in a car seat), move the infant to a crib immediately, unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health-care professional [§746.2426 and §747.2326].
- Our child care program is smoke-free. Smoking is not allowed in Texas child care operations (this includes e-cigarettes and any type of vaporizers) [§746.3703(d) and §747.3503(d)].
- Actively observe sleeping infants by sight and sound [§746.2403 and §747.2303].
- If an infant is able to roll back and forth from front to back, place the infant on the infant's back for sleep and allow the infant to assume a preferred sleep position [§746.2427 and §747.2327].
- Awake infants will have supervised "tummy time" several times daily. This will help them strengthen their muscles and develop normally [§746.2427 and §747.2327].
- Do not swaddle an infant for sleep or rest unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional [§746.2428 and §747.2328].

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### Signatures

This policy is effective on: \_\_\_\_\_ Child's name: \_\_\_\_\_

\_\_\_\_\_  
Signature — Director/Owner

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature — Staff member

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature — Parent

\_\_\_\_\_  
Date Signed



## Operational Discipline and Guidance Policy

This form provides the required information per 26 Texas Administrative Code (TAC) minimum standards §744.501(7), §746.501(a)(7), and §747.501(5).

**Directions:** Parents will review this policy upon enrolling their child. Employees, household members, and volunteers will review this policy at orientation. A copy of the policy is provided in the operational policies.

### Discipline and Guidance Policy

**Discipline must be:**

- 1) Individualized and consistent for each child;
- 2) Appropriate to the child's level of understanding; and
- 3) Directed toward teaching the child acceptable behavior and self-control.

**A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following:**

- 1) Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
- 2) Reminding a child of behavior expectations daily by using clear, positive statements;
- 3) Redirecting behavior using positive statements; and
- 4) Using brief supervised separation or time out from the group, when appropriate for the child's age and development, which is limited to no more than one minute per year of the child's age.

**There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:**

- 1) Corporal punishment or threats of corporal punishment;
- 2) Punishment associated with food, naps, or toilet training;
- 3) Pinching, shaking, or biting a child;
- 4) Hitting a child with a hand or instrument;
- 5) Putting anything in or on a child's mouth;
- 6) Humiliating, ridiculing, rejecting, or yelling at a child;
- 7) Subjecting a child to harsh, abusive, or profane language;
- 8) Placing a child in a locked or dark room, bathroom, or closet with the door closed or open; and
- 9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

### Additional Discipline and Guidance Measures

*(Only Applies to Before or After School Program (BAP)/School Age Program (SAP) that Operates under 26 TAC Chapter 744)*

**A program must take the following steps if it uses disciplinary measures for teaching a skill, talent, ability, expertise, or proficiency:**

- Ensure that the measures are considered commonly accepted teaching or training techniques;
- Describe the training and disciplinary measures in writing to parents and employees and include the following information:
  - (A) The disciplinary measures that may be used, such as physical exercise or sparring used in martial arts programs;
  - (B) What behaviors would warrant the use of these measures; and
  - (C) The maximum amount of time the measures would be imposed;
- Inform parents that they have the right to ask for additional information; and
- Ensure that the disciplinary measures used are not considered abuse, neglect, or exploitation as specified in Texas Family Code §261.001 and TAC Chapter 745, Subchapter K, Division 5, of this title (relating to Abuse and Neglect).

### Signature

This policy is effective on the following date: \_\_\_\_\_

Signed by: \_\_\_\_\_

Role:  Parent  Caregiver/Employee  Household Member (CH. 747 only)

### Minimum Standards Related to Discipline

- Title 26, Chapter 746 Subchapter L: [http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac\\_view=5&ti=26&pt=1&ch=746&sch=L&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=746&sch=L&rl=Y)
- Title 26, Chapter 747 Subchapter L: [http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac\\_view=5&ti=26&pt=1&ch=747&sch=L&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=747&sch=L&rl=Y)
- Title 26, Chapter 744 Subchapter G: [http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac\\_view=5&ti=26&pt=1&ch=744&sch=G&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=744&sch=G&rl=Y)





**FARE**  
Food Allergy Research & Education

# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma:  Yes (higher risk for a severe reaction)  No

PLACE  
PICTURE  
HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: \_\_\_\_\_

THEREFORE:

If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

## FOR ANY OF THE FOLLOWING: SEVERE SYMPTOMS



### LUNG

Shortness of breath, wheezing, repetitive cough



### HEART

Pale or bluish skin, faintness, weak pulse, dizziness



### THROAT

Tight or hoarse throat, trouble breathing or swallowing



### MOUTH

Significant swelling of the tongue or lips



### SKIN

Many hives over body, widespread redness



### GUT

Repetitive vomiting, severe diarrhea



### OTHER

Feeling something bad is about to happen, anxiety, confusion

OR A  
COMBINATION  
of symptoms  
from different  
body areas.



- INJECT EPINEPHRINE IMMEDIATELY.**
- Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
  - Consider giving additional medications following epinephrine:
    - » Antihistamine
    - » Inhaler (bronchodilator) if wheezing
  - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
  - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
  - Alert emergency contacts.
  - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

## MILD SYMPTOMS



### NOSE

Itchy or runny nose, sneezing



### MOUTH

Itchy mouth



### SKIN

A few hives, mild itch



### GUT

Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the person; alert emergency contacts.
- Watch closely for changes. If symptoms worsen, give epinephrine.

## MEDICATIONS/DOSES

Epinephrine Brand or Generic: \_\_\_\_\_

Epinephrine Dose:  0.15 mg IM  0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

PHYSICIAN/HCP AUTHORIZATION SIGNATURE

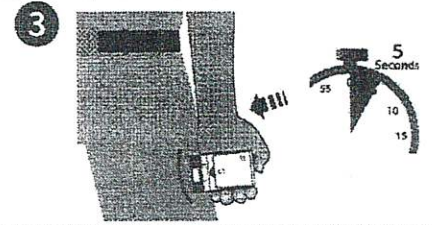
DATE





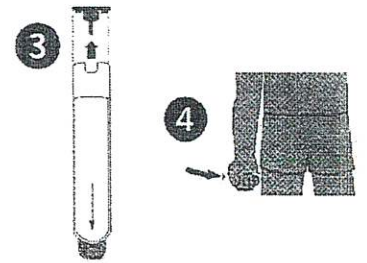
### HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



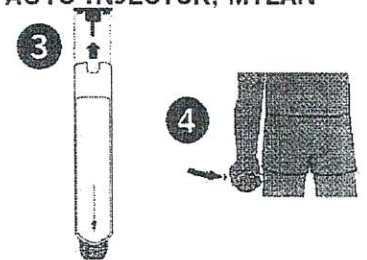
### HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



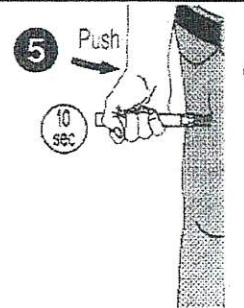
### HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



### HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



### ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

### OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

### EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: \_\_\_\_\_  
 DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

### OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: \_\_\_\_\_  
 PHONE: \_\_\_\_\_  
 NAME/RELATIONSHIP: \_\_\_\_\_  
 PHONE: \_\_\_\_\_



## New Requirements Regarding Gang-Free Zones For Child Care Centers

As a result of House Bill 2086 that passed during the 81<sup>st</sup> Legislature, Regular Session, Chapter 42 of the Human Resource Code includes section 42.064, effective September 1, 2009. This new statute requires that information about gang-free zones be distributed to parents and guardians of children in care at licensed child care centers. The following is a tip sheet to assist in complying with the new law. This information may be posted at your child care operation or copies may be provided to parents.

### ***What is a gang-free zone?***

A gang-free zone is a designated area around a specific location where prohibited gang related activity is subject to increased penalty under Texas law. The specific locations include day care centers. The gang-free zone is within 1000 feet of your child care center. For more information about what constitutes a gang-free zone, please consult sections 71.028 and 71.029 of the Texas Penal Code.

### ***How do parents know where the gang-free zone ends?***

The area that falls within a gang-free zone can vary depending on the type of location. The local municipal or county engineer may produce and update maps for the purposes of prosecution. Parents may contact their local municipality or court house for information about obtaining a copy of a map if they choose to do so.

### ***What is the purpose of gang-free zones?***

Similar to the motivation behind establishing drug-free zones, the purpose of gang-free zones is to deter certain types of criminal activity in areas where children gather by enforcing tougher penalties.

### ***What does this mean for my day care center?***

A child care center must inform parents or guardians of children attending the center about the new gang-free zone designation. This means parents or guardians need to be informed that certain gang-related criminal activity or engaging in organized criminal activity within 1000 feet of your center is a violation of this law and is therefore subject to increased penalty under state law.

### ***When do I have to comply with the new requirements?***

The law is already in effect, so providers should begin sharing information regarding gang-free zones immediately. Licensing staff will offer technical assistance to facilitate compliance until rules are proposed and adopted, which is estimated to occur in March 2010. In the meantime, providers should update their operational policies and procedures to include providing the information mandated by this law to the parents or guardians of the children in care.

*For further information please contact your licensing representative or your local licensing office.*

**Center ISD Little Riders Academy**  
**Media Release**

Many school districts publish their employees and student's names, pictures, and/or school work on media sites. In order to do this Center ISD require written permission.

Media Release

\_\_\_\_ Center ISD Little Riders Academy may post any pictures, school work and student's names containing my child to media sites.

\_\_\_\_ Center ISD Little Riders Academy may NOT post any pictures, school work and student's names containing my child to media sites.

Child's Name: \_\_\_\_\_

Parent/Guardian Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Directors Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Little Riders Academy

## Food Allergies

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

Allergy:

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Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Director's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Center ISD Little Riders Academy

## Infant Care Instruction Sheet

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Type of Formula (be specific): \_\_\_\_\_ Warmed? \_\_\_\_\_

Type of Juice(s): \_\_\_\_\_

Type of Diet: Cereal: \_\_\_\_\_ Meats: \_\_\_\_\_

Vegetables: \_\_\_\_\_ Fruits: \_\_\_\_\_

Allergies: Food: \_\_\_\_\_

Skin: \_\_\_\_\_

Other: \_\_\_\_\_

Symptoms Produced: \_\_\_\_\_

Skin Care: Ointment: \_\_\_\_\_ Special Soap: \_\_\_\_\_

Does your baby use a pacifier? \_\_\_\_\_

OTHER HELPFUL INFORMATION (Please include schedule for feedings, sleeping, etc.)

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Thank you for sharing your child with us!!

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

Note: Please update this form as changes are made. Thank you!



# Little Riders Academy

## Nutrition Release

I \_\_\_\_\_ understand that Little Riders Academy will not be held responsible for the nutritional needs of my child/ren. I understand as a parent I will be providing breakfast, snack, and lunch for my child/ren enrolled at LRA.

Child's Name: \_\_\_\_\_

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Director Signature

\_\_\_\_\_  
Date



## AUTHORIZED PICK UP FORM

Legal Guardian (Custodian) Name:

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Student's Name(s):

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The following individual(s) have our permission to pick up our child(ren) from the premises of Little Riders Academy. Proof of Identity Required. You may put as many names on the list that you feel like will need to pick up your child.

Name:	Relationship to Student & Phone Number
-------	--

Name:	Relationship to Student & Phone Number
-------	--

Name:	Relationship to Student & Phone Number
-------	--

Name:	Relationship to Student & Phone Number
-------	--

Name:	Relationship to Student & Phone Number
-------	--



# **CISD Little Riders Academy**

## Transportation Release

I \_\_\_\_\_ give permission for my child to be transported by Center ISD Transportation to Little Riders Academy.

Student Name: \_\_\_\_\_

School Campus: \_\_\_\_\_

Campus Phone Number: \_\_\_\_\_

\_\_\_\_\_

Parent Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Director Signature

\_\_\_\_\_

Date

# **Little Riders Academy**

## **Operational Policies**

This is to acknowledge that Little Riders Academy has provided a copy of the Operational Policies. On my behalf, I affirm that I have read and will comply with the Little Riders Academy Operational Policies. My signature confirms that I understand the conditions of maintaining my association with Little Riders Academy.

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**Signature of Parent/Guardian/Employee:**

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**Date:**

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**Signature of Director:**

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**Date:**



# **Little Riders Academy Parent Handbook Agreement**

I have received a copy of the Center ISD Child Development Center parent Handbook. By signing this form, I indicate that I have read and understand the handbook/discipline code.

Student Name: \_\_\_\_\_

Parent/Guardian Name Printed: \_\_\_\_\_

Date: \_\_\_\_\_

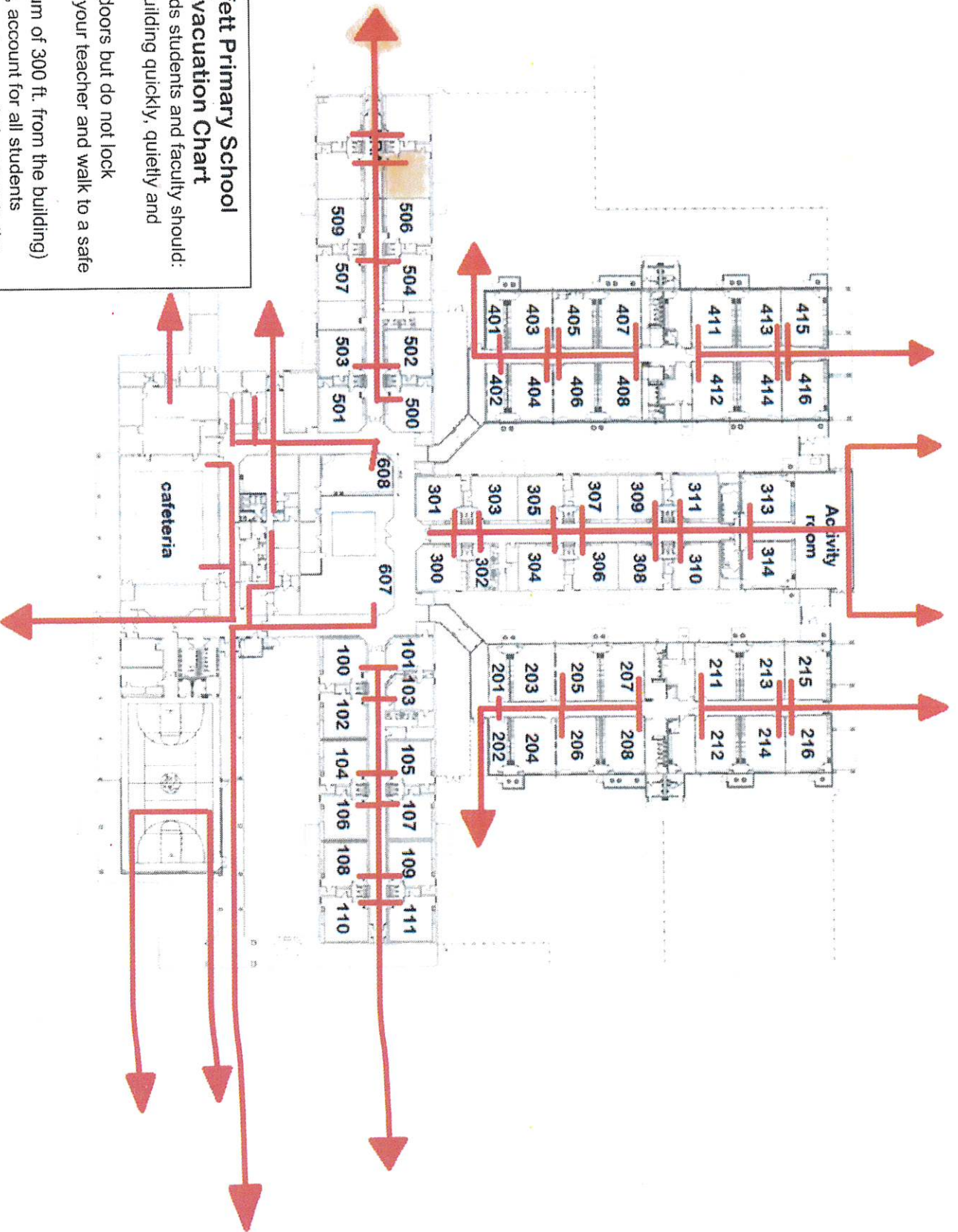
Director's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

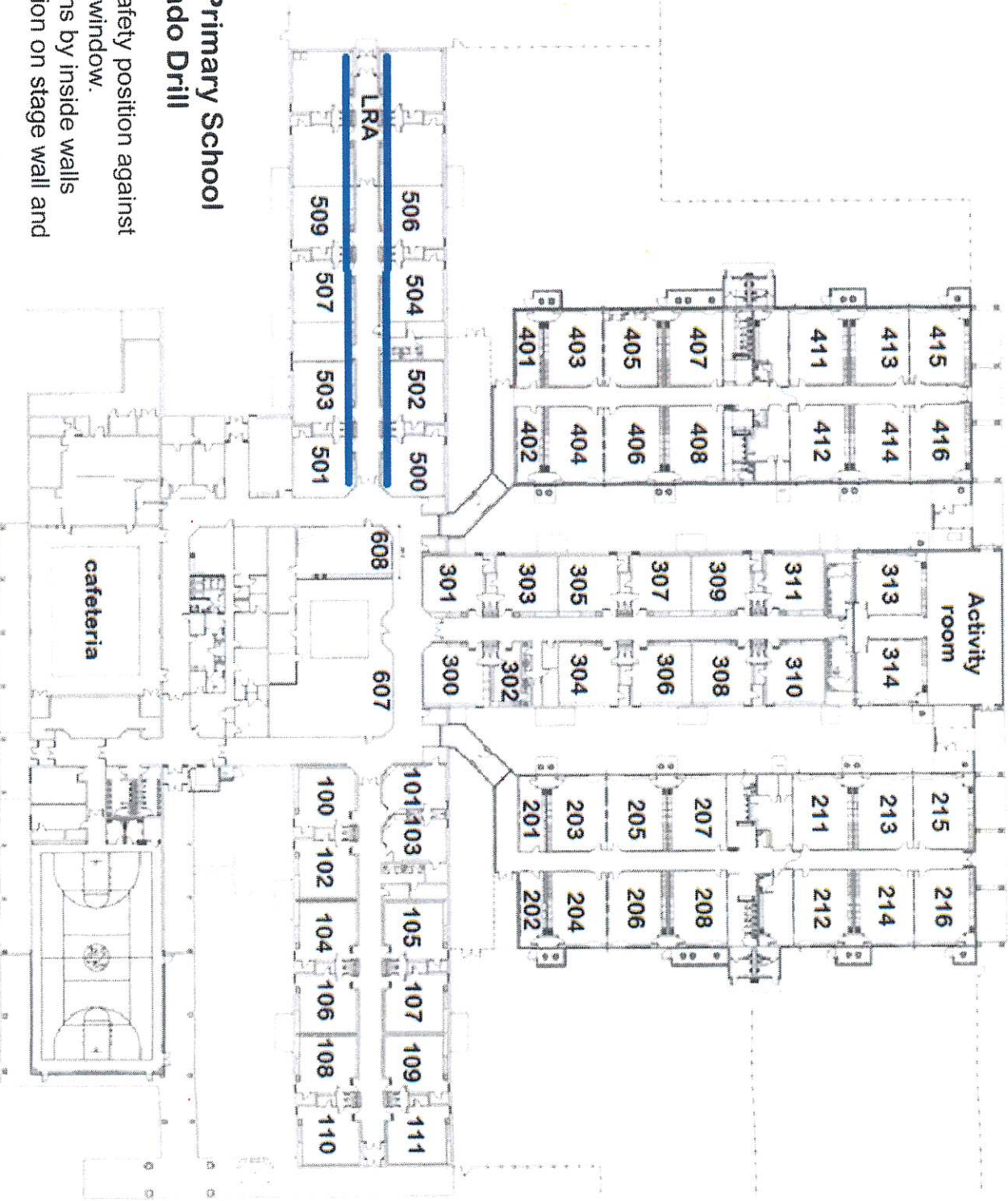
## F. L. Moffett Primary School Fire Evacuation Chart

If Fire Alarm sounds students and faculty should:

- Exit the building quickly, quietly and safely
- Close all doors but do not lock
- Stay with your teacher and walk to a safe area  
(A Minimum of 300 ft. from the building)
- Teachers, account for all students
- When alarm stops, quietly return to the building



## F.L. Moffett Primary School Tornado Drill



**Classroom wings** - Safety position against inside wall away from window.

**Library-safety** positions by inside walls

**Cafeteria-safety** position on stage wall and inside wall

**Administration/Nurse** - safety positions against inside wall